Selección de Resúmenes de Menopausia

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Unraveling the controversy: exploring the link between sex hormones and skin cancers through a meta-analysis and systematic review

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Skin cancers continue to present unresolved challenges, particularly regarding the association with sex hormones, which remains a topic of controversy. To analyze if sex hormones result in a higher incidence of skin cancers (cutaneous melanoma, basal cell carcinoma, squamous cell carcinoma). Data sources and study selection-The database of PubMed, Embase and Web of Science (WOS) was searched until July 3, 2024. The search yielded 1016 articles. 42 eligible studies were identified for meta-analysis. The primary outcome was the incidence of cutaneous melanoma and non-cutaneous melanoma. 95% CI and OR are estimate effects. Participants using oral contraceptives (OCs) showed a higher incidence of cutaneous melanoma (CM) [OR 1.08, 95%CI 1.03-1.13, $p < 0.01$]. There is positively related statistic difference in Squamous cell carcinoma (SCC) [OR 1.37, 95%CI 1.15-1.63, $p < 0.01$]. Hormone replacement therapy (HRT) was associated with a higher incidence of CM [OR 1.18, 95%CI 1.13-1.24, $p < 0.01$]. And for non-melanoma skin cancer (NMSC), HRT also increased the incidence [OR 1.13, 95%CI 1.03-1.24, $p = 0.01$]. Menopausal hormone therapy (MHT) also showed an increased incidence of CM [OR 1.09, 95%CI 1.00-1.18, $p < 0.05$]. For age at first birth, > 30 years demonstrated a positive correlation with increased the incidence of CM [OR 1.21, 95%CI 1.00-1.46, $p = 0.05$]. OCs and HRT were associated with increased risks of skin cancers. MHT elevated the risk of CM. In women whose menopause age was older than 50 years, endogenous sex hormones decreased gradually, which caused higher risks of skin cancers. First birth aged older than 30 years indicated increasing effects of skin cancers.

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Sexual function after treatment with non-invasive radiofrequency device for improvement of the genitourinary syndrome of menopause: A multi-arm randomized clinical trial

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Background: Several anatomical and functional changes occur during menopause and lead to female sexual dysfunction (FSD). The use of energy-based devices to improve women's sexual health brings an innovative scenario. Aim: To evaluate the effect of non-invasive radiofrequency (RF) treatment compared to vaginal estrogen therapy (E) and vaginal moisturizer (M) in postmenopausal women with FSD. Materials & methods: Thirty-two sexually active postmenopausal women aged 45-75 years were enrolled in a single center randomized controlled trial with three intervention arms: non-invasive RF, vaginal estrogen (E), or vaginal moisturizer (M) treatment. Assessments at baseline, and 4 months were conducted using the Female Sexual Function Index (FSFI). The primary outcome of this RCT was an assessment of the effect of RF on FSD compared to that of E and M.R esults: According to the total FSFI score, 100 % of participants in the RF and E arms and 90 % in the M arm had sexual problems at the baseline. The mean age of the participants was 58+/-5.3, 57.9+/-6.3, and 59.6+/-6.0 years in the RF, E, and M arms, respectively ($p = 0.741$). After 4 months of follow-up, FSD had ameliorated by 146.1 % in the RF arm (improvement of 17.32 points in the total FSFI score), with no significant improvement in the other arms ($p = 0.009$). We observed improvements in sexual desire (1.32 points in the partial FSFI score), arousal (2.37 points in the partial FSFI score), and orgasm (2.8 points in the partial FSFI score) only in the RF arm ($p = 0.004$, $p < 0.001$, and $p < 0.001$, respectively). Clinical implications: The use of an energy-based device independently of hormonal therapy to improve female SF is very promising. Our findings may contribute to treatment decisions when there is failure of vaginal estrogen therapy, a need for a combination of treatments, or a patient preference for the use of energy-based devices, in postmenopausal women with FSD. Conclusion: Non-invasive RF treatment for FSD showed superior efficacy compared to vaginal estrogen therapy and vaginal moisturizer after 4 months of follow-up. Further studies with longer follow-up periods are needed to corroborate these findings and evaluate the long-term effects of non-invasive RF therapy on sexual function.

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Risk of sarcopenia: A red flag for cognitive decline in postmenopause?

María S Vallejo 1, Juan E Blümel 2, Peter Chedraui, Konstantinos Tserotas, Carlos Salinas, Marcio A Rodrigues, et al.

Objective: To determine if the SARC-F tool, used to screen for sarcopenia risk, can also predict mild cognitive impairment (MCI) diagnosed with the Montreal Cognitive Assessment (MoCA) tool. Methods: This is a sub-analysis of data from a cross-sectional study carried out in postmenopausal women from Latin America (nine countries) in which sociodemographic, clinical, and anthropometric data were collected, and the SARC-F and MoCA tools administered. From the original sample of 1185 women, analysis was performed only among the 772 with natural menopause. Results: Overall, mean age, body mass index and years of education were 56.9 years, 26.8 kg/m2 and 13.6 years, respectively. Women with MCI displayed a higher body mass index, had more children, experienced more severe menopausal symptoms, and were more frequently homemakers and physically inactive. The prevalence of MCI increased from 12.9 % in women with no sarcopenia risk (SARC-F < 4 points) to 35.3 % in those at risk (OR 3.70; 95 % CI 2.36-5.80). According to binary logistic regression analysis, sarcopenia risk (total SARC-F score ≥ 4) was associated with MCI (OR: 2.44; 95 % CI 1.50-3.95). Aside from the risk of sarcopenia, being a homemaker (OR 1.97; 95 % CI 1.25-3.10) was also associated with an increased likelihood of MCI. Protective factors included ever use of menopausal hormone therapy (OR 0.26; 95 % CI 0.13-0.54) and having higher educational attainment (OR 0.28; 95 % CI 95 % 0.16-0.47). The SARC-F displayed a sensitivity of 84 % and a specificity of 39 % at diagnosing MCI.

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Salpingectomy With Delayed Oophorectomy Versus Salpingo-Oophorectomy in BRCA1/2 Carriers: Three-Year Outcomes of a Prospective Preference Trial

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Objective: To compare menopause-related quality of life (QoL) after risk-reducing salpingectomy (RRS) versus risk-reducing salpingo-oophorectomy (RRSO) until 3 years of post-surgery. Design: A prospective study (TUBA study) with treatment allocation based on patients' preference. Data were collected pre-surgery and at 3 months, 1 and 3 years of post-surgery. Setting: Multicentre prospective preference trial in thirteen hospitals in the Netherlands. Population: BRCA1/2 pathogenic variant (PV) carriers aged 25-40 (BRCA1) or 25-45 (BRCA2), who were premenopausal, without a future child wish and without current (treatment for) malignancy. Methods: Treatment allocation was based on patients' preference: either RRS from the age of 25 years with delayed oophorectomy at the maximum age of 45 (BRCA1) or 50 (BRCA2), or RRSO between the ages of 35-40 (BRCA1) or 40-45 (BRCA2). After RRSO, hormone replacement therapy (HRT) was recommended, if not contraindicated. Primarily, menopause-related QoL as measured with the Greene Climacteric Scale (GCS) was compared between the RRS and RRSO without HRT group. Secondarily, GSC-scores of the RRS group were compared with the scores of the RRSO with HRT after surgery group. A higher GSC-score reflects more climacteric symptoms. Results: Until April 2023, 410 participants had undergone RRS and 160 RRSO. The BRCA1/BRCA2 proportions were 51.4%/48.6%. The mean age at surgery (SD) was 37.9 (3.5) years. Participants 3 years after RRSO without HRT had a 4.3 (95% CI 2.1-6.5; $p < 0.001$) point higher increase in GCS-score from baseline compared to those after RRS, while the difference was 7.9 (95% CI 5.9-9.8) and 8.5 (95% CI 6.5-10.5) points at 3 and 12 months, respectively. Among participants with HRT after surgery, the RRSO group had a 2.4 (95% CI 0.8-3.9; $p = 0.002$) point higher increase in GCS-score from baseline compared to the RRS group. Conclusions: In this multicentre preference trial, menopause-related QoL was better after RRS than after RRSO, even with HRT after RRSO. Differences between arms were most pronounced until one-year post-surgery.

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Menopause-induced 17β-estradiol and progesterone loss increases senescence markers, matrix disassembly and degeneration in mouse cartilage

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Female individuals who are post-menopausal present with higher incidence of knee osteoarthritis (KOA) than male counterparts; however, the mechanisms underlying this disparity are unknown. The most commonly used preclinical models lack human-relevant menopausal phenotypes, which may contribute to our incomplete understanding of sex-specific differences in KOA pathogenesis. Here we chemically induced menopause in middle-aged (14-16 months) C57/BL6N female mice. When we mapped the trajectory of KOA over time, we found that menopause aggravated cartilage degeneration relative to non-menopause controls. Network medicine analyses revealed that loss of 17β-

estradiol and progesterone with menopause enhanced susceptibility to senescence and extracellular matrix disassembly. In vivo, restoration of 17β-estradiol and progesterone in menopausal mice protected against cartilage degeneration compared to untreated menopausal controls. Accordingly, post-menopausal human chondrocytes displayed decreased markers of senescence and increased markers of chondrogenicity when cultured with 17β-estradiol and progesterone. These findings implicate menopause-associated senescence and extracellular matrix disassembly in the sex-specific pathogenesis of KOA.

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Coronary Artery Calcium Scores After Prophylactic Premenopausal Bilateral Salpingo-Oophorectomy

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Background: Premenopausal risk-reducing salpingo-oophorectomy (RRSO) in women at high familial risk of ovarian cancer leads to immediate menopause. Although early natural menopause is associated with increased cardiovascular disease risk, evidence on long-term cardiovascular disease risk after early surgical menopause is scarce. Objectives: We sought to determine the long-term influence of the timing of RRSO on the development of coronary artery calcium (CAC), an established marker for cardiovascular disease risk. Methods: We conducted a cross-sectional study (N = 733) nested in a nationwide cohort of women at high familial risk of ovarian cancer. In women aged 60-70 years (n = 328), we compared CAC scores between women with a premenopausal RRSO (age ≤45 years) and women with a postmenopausal RRSO (age ≥54 years), using multivariable Poisson analyses. Within the premenopausal RRSO group (n = 498), we also examined the effect of age at RRSO. In addition, we compared the premenopausal RRSO group with an external reference cohort (n = 5,226). Results: Multivariable analyses showed that the prevalence rates of any CAC (CAC >0), at least moderate CAC (CAC >100), and severe CAC (CAC >400) were comparable between the premenopausal and postmenopausal RRSO groups (relative risk [RR]: 0.93; 95% CI: 0.75-1.15 for any CAC; RR: 0.71; 95% CI: 0.43-1.17 for at least moderate CAC; RR: 0.81; 95% CI: 0.30-2.13 for severe CAC). There was no difference in CAC between the premenopausal RRSO group and a similar aged reference cohort. Timing of premenopausal RRSO (early premenopausal RRSO [<41 years] vs late premenopausal RRSO [41-45 years]) did not affect the outcomes. Conclusions: Our results do not show a long-term adverse effect of surgical menopause on the development of CAC.

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Screening for Osteoporosis to Prevent Fractures: US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force; Wanda K Nicholson 1, Michael Silverstein, John B Wong, David Chelmow, et al.

Importance: Osteoporotic fractures are associated with psychological distress, subsequent fractures, loss of independence, reduced ability to perform activities of daily living, and death. Objective: The US Preventive Services Task Force (USPSTF) commissioned a systematic review to evaluate the evidence on the benefits and harms of screening for osteoporosis to prevent fractures in adults 40 years or older with no known diagnosis of osteoporosis or history of fragility fracture. Population: Adults 40 years or older without known osteoporosis or history of fragility fractures. Evidence assessment: The USPSTF concludes with moderate certainty that screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older has moderate net benefit. The USPSTF concludes with moderate certainty that screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years at increased risk has moderate net benefit. The USPSTF concludes that the evidence is insufficient and the balance of benefits and harms for screening for osteoporosis to prevent osteoporotic fractures in men cannot be determined. Recommendation: The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older. (B recommendation) The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men. (I statement).